MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13 1a

09486

CERTIFICATE OF DEATH

Reg. Dist. No. 354

1. PLACE OF DEATH:

County: Worcester

City or town: Stockton Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Stockton
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Custis

Minnie Custis Archer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	married

6.(b) Name of husband or wife: George W. Archer

6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): Mar. 24 1888

8. AGE:

Years	Months	Days	If less than one day
59	6	20	hrs. min.

9. Birthplace: Stockton Md
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Peter William Tull
13. Birthplace: Stockton Md

MOTHER
14. Maiden name: Mary Ann Powley
15. Birthplace: Stockton Md

16. Informant: David Harmon
Address: N.J.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 17. 1947 (month) (day) (year)

Cemetery or crematory: Home Burying Ground Cemetery

Location: Stockton Md

18. Funeral director: Irvine Bennett

Address: Stockton md

19. Oct. 17 1947 (Date rec'd by registrar) Mary M. Taylor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 14 1947, at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 1947 to Oct 14 1947 and that I last saw her alive on Oct. 13 1947

Immediate cause of death	DURATION
Cerebral Vascular Accident	2 wks
Due to: Hypertensive Cardiovascular renal disease	10 yrs.
Due to:	
Other conditions: Hemiplegia Left Side duration	4 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert L. LaMar M.D.
M. D. or other

Address: Greenhill Date signed: 10-15-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09487

13 d

CERTIFICATE OF DEATH

Reg. Diat. No. 351

1. PLACE OF DEATH:
County: Worcester
City or town: Girdletree Rural #1
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 37 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Girdletree
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: NO

3.(a) FULL NAME: Mary J. Beider

3.(b) Social Security Number: None

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: John E. Beider
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Sept. 12 - 1856
8. AGE: Years: 91 Months: 0 Days: 21 If less than one day: hrs. min.
9. Birthplace: Singac (Town, county, and state) New Jersey
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Frederick Vanness
13. Birthplace: New Jersey
MOTHER 14. Maiden name: Katherine Zeloff
15. Birthplace: New Jersey
16. Informant: Mrs. Lillie Bunting
Address: Girdletree, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 5 '47 (month) (day) (year)
Cemetery or crematory: Mt. Hill
Location: Girdletree Md.
18. Funeral director: LeRoy E. Dennis
Address: Snow Hill Md.
19. 10/4/1947 (Date rec'd by registrar) LeRoy Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 3 1947 at 10 16 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 to Oct 3 1947 and that I last saw her alive on Oct 2 1947

	DURATION
Immediate cause of death: Myocardial degeneration	years
Due to: Age	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: G. Whitaker M. D.
M. D. or other
Address: Snow Hill Md. Date signed: 10-3-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93c

09488

CERTIFICATE OF DEATH

Reg. Dist. No. 351

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Worcester

City or town Snow Hill md R.F.D. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Seventeen years

Hospital, institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Worcester

City or town Snow Hill md R.F.D. No 1 (If outside city or town limits, write RURAL and give nearest town)

Street No. no (If rural, give LOCATION)

2.(a) If veteran, name war no

3. (a) FULL NAME Bonnie Carey

3. (b) Social Security Number no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	a.a.	Single

6.(b) Name of husband or wife no

6.(c) If alive, give age no years

7. Birth date of deceased (mo., day, yr.) Sept 19 1929

8. AGE: Years 18 | Months 1 | Days 2 | If less than one day ... hrs. ... min.

9. Birthplace Berlin md (Town, county, and state)

10. Usual occupation School

11. Industry or business no

FATHER 12. Name Joseph Carey

13. Birthplace Newark Md

MOTHER 14. Maiden name Dorothea Postelle

15. Birthplace Harpers Ferry W Va

16. Informant Mrs Joseph Carey

Address Snow Hill md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 3 1947 (month) (day) (year)

Cemetery or crematory Ebenezer

Location Snow Hill md

18. Funeral director Parnell D. Stewart

Address Salisbury Md

19. 11/3 1947 (Date rec'd by registrar) R. Ray Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 31 Oct 19 47 at 4 a. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 19 46 to 31 Oct 19 47

and that I last saw h[illegible] alive on 30 Oct 19 47

Immediate cause of death Chronic Rheumatic Myocarditis, Cardiac Dilitation, Due to Rheumatic Fever & Carditis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Hermann Habbenden M. D. or other

Address 5 Bay Shore, Berlin Date signed 31 Oct 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(0948) 942

Reg. Dist. No. 355

1. PLACE OF DEATH:

County: Worcester

City or town: Whaleyville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1yr

Hospital, Institution, or street address where death occurred: x

How long in hospital or institution? x

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Whaleyville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: X

(If rural, give LOCATION)

2.(a) If veteran, name war: X

3. (a) FULL NAME: PETER WILLIAM DALE

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife: Elizabeth Dale

6.(c) If alive, give age: 37 years

7. Birth date of deceased (mo., day, yr.): June 26 1904

8. AGE: Years	Months	Days	If less than one day
43	3	19	....hrs. ....min.

9. Birthplace: Whaleyville (Town, county, and state)

10. Usual occupation: Filling Station Prop.

11. Industry or business:

FATHER — 12. Name: Milton M. Dale

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Elizabeth Powell

15. Birthplace: Md.

16. Informant: Mrs. Annie Taylor

Address: Whaleyville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 17, 1947 (month) (day) (year)

Cemetery or crematory: Whaleyville

Location: Whaleyville

18. Funeral director: McCabe Watson

Address: Selbyville Del

19. 10-15 1947 (Date rec'd by registrar) Helen S. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 15 Oct 1947 at 6 30 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 15, 1947 to Oct 1947

and that I last saw h(im) alive on 15 Oct 1947

Immediate cause of death: Acute Coronary Thrombosis — DURATION: 12 hrs.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of ....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Herman A Robbins M.D. (M. D. or other)

Address: 5 Bay St Berlin Date signed: 15 Oct 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

09490

Reg. Dist. No. 355

1. PLACE OF DEATH:

County Worcester

City or town Showells

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Worcester

City or town Showells

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Florence Mabala Davis.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widow

6.(b) Name of husband or wife: D. Stanton Davis

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 25, 1869

8. AGE: Years 78 | Months 1 | Days 7 | If less than one day ..... hrs. ..... min.

9. Birthplace: Berlin Worc Co Md. (Town, county, and state)

10. Usual occupation: Housewife.

11. Industry or business

FATHER 12. Name: Watson Fiske

13. Birthplace: Md.

MOTHER 14. Maiden name: Hettie Fiske

15. Birthplace: Md.

16. Informant: Mrs. John Bishop

Address: Showells Md

17. Bur (Burial, cremation, or removal. Which?) Date thereof 10/8/47 (month) (day) (year)

Cemetery or crematory: Evergreen

Location: Berlin Md

18. Funeral director: Denn A Bunting

Address: Berlin - Md.

19. 10-8- 1947 (Date rec'd by registrar) Helen L. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5 Oct 1947 at 5 30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 27 July 1947 to 5 Oct 1947 and that I last saw h.. alive on 5 Oct 1947

Immediate cause of death	DURATION
Chronic Degeneration	
Myocarditis & adiposclerosis	
Cardio Hypertension	
Due to: Bronchial Asthma, obesity	
& arteriosclerosis -	
Due to:	
Other conditions: senility	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE Hermenia Harbers M.D. M. D. or other

Address 5 Bay St, Berlin Md Date signed 7 Oct 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

47d

09491

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH:

County: Worcester

City or town: Ocean City (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years

Hospital, institution, or street address where death occurred: Philadelphia Ave. and 5th St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Ocean City (If outside city or town limits, write RURAL and give nearest town)

Street No.: Philadelphia Ave. and 5th St. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: William Edwin Hastings

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Maude Hastings

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 2, 1893

8. AGE: Years	Months	Days	If less than one day
54	8		..... hrs. ..... min.

9. Birthplace: Berlin R.F.D. Wor. Md. (Town, county, and state)

10. Usual occupation: Fisherman

11. Industry or business: Ocean Net Fishing

FATHER — 12. Name: Henry Hastings

FATHER — 13. Birthplace: Berlin R.F.D. Md.

MOTHER — 14. Maiden name: Minnie O. Smith

MOTHER — 15. Birthplace: Berlin, Md.

16. Informant: Maude Hastings

Address: Ocean City, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 6, 1947 (month) (day) (year)

Cemetery or crematory: Evergreen Cemetery

Location: Berlin, Md.

18. Funeral director: [illegible] T. Burbage

Address: Berlin, Md.

19. 10-6- 1947 Helen F. Hayward (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1 October 1947 at 6:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1947 to 1 Oct 1947 and that I last saw him alive on 1 Oct 1947

Immediate cause of death	DURATION
Carcinoma of Lung, (Bronchogenic)	2 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Nathaniel F. Thomas M. D. or other

Address: Ocean City, Md. Date signed: 4 Oct 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

09492

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:
County Worcester
City or town Pocomoke City. R.F.D. 1
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Pocomoke City R. F. D. 1
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Webster R. Hayward

3. (b) Social Security Number

4. Sex: Male
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) Feb, 28. 1909

8. AGE: Years	Months	Days	If less than one day
38	7	7	... hrs. ... min.

9. Birthplace Marion Sta, Somerset, Md,
(Town, county, and state)
10. Usual occupation Farm Labor
11. Industry or business

FATHER
12. Name Henry Hayward
13. Birthplace Somerset Co, Md,

MOTHER
14. Maiden name L . Miles
15. Birthplace Somerset Co, Md,

16. Informant Julian Hayward
Address Pocomoke City, Md, R. F. D. 1

17. Burial Date thereof 10/8/47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory St Lukes Cemetery
Location Rehobet Rd Somerset Co.
18. Funeral director Howard A. Gill
Address Pocomoke City, Maryland
19. Oct 8 1947 Anne E. White
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5. 1947, at 7 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 4 1947, to Oct 5 1947
and that I last saw him alive on Oct 4 1947

Immediate cause of death	DURATION
[illegible]	2
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [illegible signature] M. D. or other
Address [illegible] Date signed 10-6-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

09493

CERTIFICATE OF DEATH

Reg. Diat. No. 354

1. PLACE OF DEATH:
County: Worcester
City or town: Stockton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yrs.
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Stockton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME: David W. Johnson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Virginia Johnson
6.(c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.): Aug. 6, 1893

8. AGE:

Years	Months	Days	If less than one day
54			hrs. min.

9. Birthplace: Brahopville (Town, county, and state)
10. Usual occupation: Checker Plant
11. Industry or business:
FATHER 12. Name: Thomas Johnson
13. Birthplace: Md.
MOTHER 14. Maiden name: Elizabeth Savage
15. Birthplace: Md
16. Informant: Virgie Johnson
Address: Stockton. Md.
17. Buried (Burial, cremation, or removal. Which?) Date thereof: Oct 9, 1947 (month) (day) (year)
Cemetery or crematory
Location: Stockton. Md.
18. Funeral director: Mrs. M. Basha Watson
Address: Selbyville, Del.
19. Oct 8, 1947 (Date rec'd by registrar) Mary M. Taylor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 7, 1947 at 900 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1947 to Oct 7 1947 and that I last saw him alive on Oct. 6 1947

Cause	DURATION
Immediate cause of death: acute pulmonary Edema	2 wks
Due to: Hypertensive Cardiovascular Renal Disease	5 yrs
Due to:	
Other conditions: Right hemiplegia due to Cerebral vascular accident (Including pregnancy within 3 months of death)	7 wks

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert L. LaMar M.D. M. D. or other
Address: Snow Hill Date signed: 10-7-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

09494

CERTIFICATE OF DEATH

Reg. Diat. No. 355

1. PLACE OF DEATH:

County: Worcester

City or town: Berlin R F D

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Worcester

City or town: Berlin R F D

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: John Elmer Jones

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Tiney Jones

6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): Jan. 28, 1884

8. AGE:

Years	Months	Days	If less than one day
63	8	24	..... hrs. ..... min.

9. Birthplace: Ocean City Md (Town, county, and state)

10. Usual occupation: Retired Painter

11. Industry or business

FATHER

12. Name: Capt. John Jones

13. Birthplace: Md

MOTHER

14. Maiden name: Martha Anne Jenkins

15. Birthplace: Md

16. Informant: Mrs. J. Elmer Jones

Address: Berlin Md R F D.

17. (Burial, cremation, or removal. Which?) B — Date thereof: 10/26/47 (month) (day) (year)

Cemetery or crematory: Evergreen

Location: Berlin Md

18. Funeral director: Owens & Barbaya

Address: Berlin Md

19. 10-26-47 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 23 1947 at 12:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1946 to Oct 23 1947 and that I last saw him alive on Oct 23 1947

	DURATION
Immediate cause of death: Coronary occlusion	2 wks
Due to: Arteriosclerosis	2 yrs +
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Nathaniel R. Thomas M. D. or other

Address: Decard City, Md Date signed: 23 Oct 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13/a

CERTIFICATE OF DEATH

09495

Reg. Dist. No. 355

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County Worcester

City or town Berlin

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 70 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Worcester

City or town Berlin

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary Ellen Marshall.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	single.

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 30, 1877

8. AGE: Years	Months	Days	If less than one day
70	1	19	..... hrs. ..... min.

9. Birthplace Maryland. (Town, county, and state)

10. Usual occupation housewife

11. Industry or business Housekeeping

FATHER 12. Name Charles P. Marshall

13. Birthplace Maryland

MOTHER 14. Maiden name Sally A. Tatgleman

15. Birthplace Maryland.

16. Informant Mrs. Columbus Marshall

Address Berlin Md

17. Burial, cremation, or removal. Which? Burial Date thereof 10/21/47 (month) (day) (year)

Cemetery or crematory Evergreen

Location Berlin Md

18. Funeral director Dana A. Burbage

Address Berlin Md

19. 10-20 1947 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 19 1947, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 1947 to Oct 19 1947 and that I last saw her alive on Oct 15 1947

Immediate cause of death	DURATION
Chronic Cut Nephritis	
Due to Hypertension	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Oxford E. Abbott M. D. or other

Address Berlin Md. Date signed 10-20-47

VS A15 9.45.15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170C

09496

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:
County Worcester
City or town Rural Beaver Dam Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 month
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Virginia County Highland
City or town Monterey
(If outside city or town limits, write RURAL and give nearest town)
Street No. Spruce St.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME Martha Jane McNulty
3. (b) Social Security Number —

4. Sex Female
5. Color or race White
6. (a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Thomas S. McNulty
6.(c) If alive, give age 31 years
7. Birth date of deceased (mo., day, yr.) January 31 - 1921
8. AGE: Years 26 Months 8 Days 10 If less than one day ... hrs. ... min.
9. Birthplace Crabbottom Highland Va.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Paul L. Mauzy
13. Birthplace Virginia
MOTHER 14. Maiden name Maggie Simmons
15. Birthplace Virginia
16. Informant Thomas S. McNulty
Address NAS Chincoteague Va.
17. Burial Date thereof Oct. 15 - 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory
Location Bluegrass Virginia
18. Funeral director Henry H. Watson
Address Pocomoke Md.
19. Oct. 12, 1947 Anne E. White
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11 1947 at 8:05 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on Oct 11th 1947
Immediate cause of death Head injuries with cranial hemorrhage Probably - Fractured Skull — DURATION: Instant
Due to Auto - Collision
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Auto Accident Date of 10/11/47
Where did injury occur Rural Beaver Dam Worcester Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) On State Highway
Means of injury Auto Injured at work? No
23. SIGNATURE [illegible] M.D. Med. Examiner
M. D. or other
Address Pocomoke City Md Date signed 10/12/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

09497

Reg. Diat. No. 355

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: WORCESTER

City or town: BERLIN

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 73 YEARS.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: MD. County: WORCESTER

City or town: BERLIN

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: VIRGINIA MITCHELL

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOW

6.(b) Name of husband or wife: FRANK A. MITCHELL

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): FEB. 22, 1874.

8. AGE:

Years	Months	Days	If less than one day
73	8	14	..... hrs. ..... min.

9. Birthplace: BERLIN, WOR. CO., MD.

(Town, county, and state)

10. Usual occupation: HOUSEWIFE.

11. Industry or business

FATHER

12. Name: CHARLES M. BAKER.

13. Birthplace: MD.

MOTHER

14. Maiden name: MARY RICHARDSON

15. Birthplace: MD.

16. Informant: MR. CLAYTON BAKER.

Address: BERLIN, MD.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 10/8/47 (month) (day) (year)

Cemetery or crematory: EVERGREEN

Location: BERLIN, MD.

18. Funeral director: Anna A. Burbage

Address: BERLIN, MD

19. 10-8 1947 (Date rec'd by registrar) Helen E. Hayward Registrar

MEDICAL CERTIFICATION

Oct. 6

20. DATE OF DEATH: OCT. 6 19 47, at 6 50 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19 47, to OCT. 6 19 47

and that I last saw her alive on OCT. 6 19 47

Immediate cause of death: Chronic degeneration myocarditis & arterio-sclerosis cerebral block.

Due to: ARTERIO SCLEROSIS

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Hermanda Robbins M.D. M. D. or other

Address: Main St. Berlin, MD Date signed: 7 Oct 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 53

09498

CERTIFICATE OF DEATH

Reg. Diat. No. 351

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH: Worcester
County
City or town: Snow Hill (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, institution, or street address where death occurred: Market St. Ext.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)
Street No. 551 S. Dividen St. (If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME: Clayton Wanfield Parsons
3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widower
6.(b) Name of husband or wife: Dorilla Parsons
6.(c) If alive, give age: Dead years
7. Birth date of deceased (mo., day, yr.): Nov. 14-1867

8. AGE: Years 79 Months 10 Days 26 If less than one day hrs. min.
9. Birthplace: R.D. Salisbury Md. (Town, county and state)
10. Usual occupation: Retired Farmer
11. Industry or business
FATHER 12. Name: Joshua J. Parsons
13. Birthplace: R.D. Salisbury Md.
MOTHER 14. Maiden name: Mary E. Buttingham
15. Birthplace: R.D. Salisbury Md.
16. Informant: Mrs. Beatrice Adkins
Address: Market St. Ext. Snow Hill, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 13-1947 (month) (day) (year)
Cemetery or crematory: Parsons Cemetery
Location: Salisbury Maryland
18. Funeral director: Dillon & Co. Walter R. Dillon
Address: Salisbury Maryland.
19. (Date rec'd by registrar) 10/13/1947 Registrar: LeRoy Smith

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 10 1947 at 1 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 10 1947 to Oct 10 1947 and that I last saw alive on Oct 10 1947

	DURATION
Immediate cause of death: Acute Pulmonary Edema	1 hr.
Due to: Anemia, Senility & Chronic Cardiac Failure	2 yrs.
Due to: Malignant Melanoma of Toe	5 yrs
Other conditions: Liver Metastases	

(Include pregnancy within 3 months of death)

Major findings of operation: Amputation of Malignant Melanoma Left foot Date of op. Sept. 19-47
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Manner of injury: Injured at work?

23. SIGNATURE: [illegible] La Mar Md. M. D. or other
Address: Snow Hill Date signed 10-10-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46e

09499

CERTIFICATE OF DEATH

Reg. Diat. No. 955

1. PLACE OF DEATH:

County: Worcester

City or town: Berlin

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Worcester

City or town: Berlin

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME KENDALL THEODORE TAYLOR,

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: Virginia Taylor

6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): Feb. 8, 1878.

8. AGE:

Years	Months	Days	If less than one day
69	8	16	hrs. min.

9. Birthplace: Berlin Md (Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business

FATHER

12. Name: Dwight H. Taylor

13. Birthplace: Md.

MOTHER

14. Maiden name: Cordelia Harmon

15. Birthplace: Md.

16. Informant: Mrs K. T. Taylor

Address: Berlin Md R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/26/47 (month) (day) (year)

Cemetery or crematory: Evergreen

Location: Berlin Md

18. Funeral director: Duncan A Bunting

Address: Berlin Md

19. 10-26 1947 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 24 Oct 1947 at 2 45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 May 1947 to 24 Oct 1947 and that I last saw h. alive on 24 Oct 47 1947

Immediate cause of death: Intestinal Obstruction — DURATION

Due to: Peritoneal Carcinomatosis — 7 mos

Due to: Carcinoma Transverse Colon

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation: Carcinoma Transverse Colon, Obstruction Date of op. May 15 47

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Herman A Robbins M D

M. D. or other

Address: Berlin, Md Date signed 25 Oct 47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170c 09500

CERTIFICATE OF DEATH

Reg. Diat. No. 355

1. PLACE OF DEATH:

County: Worcester

City or town: Berlin R F D

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 years

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Worcester.

City or town: Ocean City Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Helen Adilia Turner.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married.

6.(b) Name of husband or wife: Howard Turner.

6.(c) If alive, give age: 46 years

7. Birth date of deceased (mo., day, yr.): Sept. 29, 1908

8. AGE:

Years	Months	Days	If less than one day
39	0	4	....hrs. ....min.

9. Birthplace: Berlin Wor Co Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Edward Richardson

FATHER — 13. Birthplace: Md.

MOTHER — 14. Maiden name: Mamie Carey.

MOTHER — 15. Birthplace: Maryland.

16. Informant: Mrs. Wm Tilghman

Address: Ocean City Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/6/47 (month) (day) (year)

Cemetery or crematory: Evergreen.

Location: Berlin Md.

18. Funeral director: Anna A Burbage

Address: Berlin Md

19. 10-6- 1947 Helen F. Hayward Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10-3 1947, at 6 30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19.... to ....19....

and that I last saw h... alive on Oct 3rd 1947

Immediate cause of death	DURATION
Fracture of Skull with Brain Cut Just after the tournament started	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, homicide: Accidental Date of 10/3/47

Where did injury occur? Cross Roads Near Newark Bridge Worcester Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) State Highway (See above)

Means of Injury: Auto - Accident Injured at work? No

23. SIGNATURE: N E Gastorena M.D. M. D. or other

Address: Pocomoke City Md Date signed: 10/3/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct name is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

930 09501 351

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Worcester

City or town: Snow Hill Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Snow Hill Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: William Douglas Young

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Colored	widower

6.(b) Name of husband or wife: Ellen Young

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): November 1867

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
unknown 80				

9. Birthplace: Accomac Co. Virginia
(Town, county, and state)

10. Usual occupation: retired farmer

11. Industry or business: —

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: Sarah Taylor
15. Birthplace: unknown

16. Informant: Mrs. Ellen Armstrong
Address: Snowhill Md. R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 22 1947 (month) (day) (year)

Cemetery or crematory: Bayside

Location: Mt. Onancock, Virginia

18. Funeral director: J. Edgar Thomas

Address: Accomac, Virginia

19. 10/21/47 (Date rec'd by registrar) Leroy Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 18 1947 at 4.45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1947, to Oct 18 1947

and that I last saw him alive on Oct 16 1947

Immediate cause of death	DURATION
Hypertensive Myocarditis	unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ____ Injured at work?

23. SIGNATURE: Paul Cohen M.D.
M. D. or other

Address: Snow Hill Date signed 10/21/47